

# NEUROLOGY HEADACHE HISTORY QUESTIONNAIRE

TODAY'S DATE \_\_\_\_\_

NAME OF PATIENT \_\_\_\_\_

AGE \_\_\_\_\_ BIRTH DATE \_\_\_\_\_

HOW LONG HAS HE/SHE HAD THE HEADACHES \_\_\_\_\_

DO HEADACHES LAST FOR: MINUTES / HOURS / DAYS / WEEKS

ARE THE HEADACHES: EVERYDAY / 1-2 A WEEK / 1-2 A MONTH / 1-2 A YEAR / FIRST TIME

WHERE IN THE HEAD DOES IT HURT \_\_\_\_\_

DO THEY WAKE HIM/HER \_\_\_\_\_

HEADACHE SEVERITY: Least Worst  
1      2      3      4      5      6      7      8      9      10

ARE THE HEADACHES: POUNDING / PRESSURE LIKE / SQUEEZING / SHARP / DULL ACHE

DO LIGHT AND SOUND BOTHER WHEN HAVING HEADACHES \_\_\_\_\_

DOES SLEEPING HELP \_\_\_\_\_

ARE HEADACHES WORSE: WAKING UP / DAYTIME / AFTERNOONS / EVENINGS / NIGHT

LIST ALL MEDICATIONS USED \_\_\_\_\_

WHAT MEDICINE WORK BEST \_\_\_\_\_

WHAT RELIEVES THE HEADACHES \_\_\_\_\_

WHAT BRINGS ON THE HEADACHES \_\_\_\_\_

ANY NAUSEA OR VOMITTING \_\_\_\_\_

ANY ASSOCIATED FEATURES: BLURRED VISION / DOUBLE VISION / DIZZINESS /

WEAKNESS / PARALYSIS / \_\_\_\_\_

ANY OTHER FAMILY MEMBERS WITH HEADACHES \_\_\_\_\_

ARE THE HEADACHES SIMILAR (IF NO EXPLAIN) \_\_\_\_\_

ANY TESTING DONE SO FAR \_\_\_\_\_

RESULTS OF THOSE TESTS \_\_\_\_\_

ANYTHING ELSE YOU WANT TO EXPLAIN ABOUT THESE HEADACHES \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_